An Assessment/Placement Model for Long Term Care Services in Alberta

APPROVED BY THE

INTERDEPARTMENTAL COMMITTEE ON LONG TERM CARE

October 1984

(Edited, January 1985)

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EXECUTIVE SUMMARY

INTRODUCTION

There is a general concern, in the Province of Alberta, for the quality of care for our elderly. In addition, there is concern for cost efficiency in the delivery of long term care services. These concerns have been documented in a number of formal reports and are being addressed by the Interdepartmental Committee on Long Term Care, whose members represent the Departments of Hospitals and Medical Care, Social Services and Community Health, Housing and the Alberta Mortgage and Housing Corporation.

An assessment/placement model has been proposed by the Interdepartmental Committee to address the concerns for quality and cost of services. The model is to be pilot tested in two regions of the Province where the local providers of long term care services are interested and supportive of the proposed model.

This paper describes single entry assessment, the proposed single entry model, and proposed implementation.

WHAT IS SINGLE ENTRY ASSESSMENT?

Single entry assessment provides one integrated, comprehensive assessment procedure for long term care clients. It is a means of streamlining entry into long term care services, including community based home care programs and placement in nursing homes and auxiliary hospitals. Single entry assessment establishes one point of contact, in each community, to initiate long term care, and performs a case management function for each client.

BENEFITS

Single entry assessment brings a number of benefits:

Firstly, there is better service to the client. Consideration is given to all service options available. There is less confusion for the client and family. There is an emphasis upon client need and attention to client preferences. A special effort is made to make an objective and comprehensive assessment and to provide appropriate services as well as case planning and management help to assure better service to the client.

Secondly, the implementation of single entry assessment acknowledges all placement options available to the clients and provides more opportunity for people to receive community based services.

Thirdly, there is coordination of programs and services to reduce duplication of effort.

Fourthly, efficiency increases with appropriate use of resources and a shift in emphasis to community based services.

PRINCIPLES

These are the principles underlying the single entry model:

Consideration of the level of functioning and provision of appropriate care, related to client need.

Maintenance and strengthening of family and community.

Involvement of the client in solving problems.

Recognition that assessment and placement are separate functions: first, assessing for client care needed; then, planning for the provision of

care, identifying services and/or accommodation available and facilitating access to needed services and/or accommodation.

Ensuring good placement decision making by encouraging the use of the most appropriate services and including all long term care service providers as responsible participants in the long term care system.

Responding promptly to referrals and needs.

Ensuring case management, which is the process of assessing a person's needs, establishing a plan to deal with these needs, implementing the plan directly or by referral, and finally ensuring that the plan has been carried out or revised as necessary on an ongoing basis.

Establishment of an independent appeal process for clients, physicians and service providers.

PRESENT SYSTEM

In the present system, referrals can be made by anyone, to any service. Assessments are done by a variety of agencies to determine client eligibility. This process does not focus on client needs. Reassessment is not always a formalized aspect of the system.

In the single entry model, anyone may still make a referral, but there is one point of contact in each community. The assessment/placement process centers upon the client and his need and has three key components: the Home Care Case Coordinator, the Institutional Case Coordinator and the Regional Assessment/ Placement Committee.

KEY COMPONENTS

The Home Care Case Coordinator is a fully qualified professional who receives all referrals for long term care services for people residing in the community. The case coordinator assesses the client and identifies the care required. She contacts the client's physician for information and also, if

appropriate, for the authorization needed to receive community based services or institutional care. She also refers clients needing institutional placement to the Institutional Case Coordinator. She is responsible for regular assessment of clients to ensure that the community based care provided is appropriate and for discharge planning, when these services are no longer needed. She provides regular reports to the Regional Assessment/Placement Committee regarding the volume of assessments, the number of clients maintained in the community, the number referred for institutional placement and so forth.

The Institutional Case Coordinator receives referrals from the Home Care Case Coordinator and from institutions when the client needs placement in a long term care facility. She determines the institutional care requirements and manages existing waiting lists for institutional care. She assists with institutional discharge planning referring clients, as appropriate, to the Home Care Case Coordinator. She is responsible to the Chairperson of the Regional Assessment/Placement Committee.

The Regional Assessment/Placement Committee has overall responsibility for assessment/placement in regions. It recruits the Institutional Case Coordinator and ensures supervision of this position. It reviews regular reports from the Home Care Case Coordinator regarding assessment of long term care clients and also concerning situations where high cost clients are being maintained in the community. The Committee has an ongoing role in assessing the availability of regional resources and acting to facilitate meeting any gaps in service. The Committee will include representatives of non-institutional and institutional services and consumer groups and will make reports to the Interdepartmental Committee on Long Term Care.

A Regional Committee may appoint, if desired, a Regional Institutional Placement Panel which would review recommendations for institutional placement and advise the Home Care and Institutional Case Coordinators. This panel would include a physician, nurse, social worker and rehabilitation therapist selected by the Regional Committee.

ASSESSMENT PROCESS AND CLIENT RIGHTS

There are two aspects of the single entry model which are particularly important to the improvement of services to clients. One of these is the client assessment process; the other is client rights.

The client assessment process will involve the use of a client centered assessment tool to be developed under the direction of professional representatives of all long term care services. It will obtain information about the total person, his medical condition and physical functioning, his social and emotional needs, his living arrangements and support systems. It is intended that the assessment process may include referral for additional assessment and special consultation. Assessment data will be obtained from a variety of sources with client permission. The assessment will involve friends and family, if appropriate. It will be repeated regularly to ensure that services provided are appropriate and needed, and to identify any changes required.

Client rights will be assured through client involvement in the decision for care and respect for client choice and independence. The client will also have the right to appeal the initial assessment and/or decision on home care services, decisions regarding type of placement and the specific institution recommended. This right of appeal is also available to family, physician, and service providers. The Home Care and Institutional Case Coordinators may receive appeals, which they will promptly refer to the appeal body, the Regional Assessment/Placement Committee.

IMPLEMENTATION

As indicated, the assessment/placement model is to be pilot tested. It is anticipated that a trial period of two years will be required and during that time the model may well be adjusted as the advantages and disadvantages of various structures are evaluated. Local interest and support will be taken into consideration when the regions for the pilot tests are determined. The boundaries for these regions will be negotiable. The regions should be large enough to allow for adequate regional resources but small enough to ensure that clients retain a sense of community. Nursing home and auxiliary hospital

districts may provide a basis for regional boundaries, with consideration given to Health Unit boundaries.

During the trial period, the assessment and placement services in other parts of the Province will remain unchanged.

AN ASSESSMENT/PLACEMENT MODEL FOR LONG TERM CARE SERVICES IN ALBERTA

1. Background: Single Entry Assessment

The three Departments (Hospitals and Medical Care, Social Services and Community Health, and Housing) and the Alberta Mortgage and Housing Corporation believe that a co-ordinated assessment and placement service or a single point of entry for long term care* in Alberta is essential. Single entry assessment is an integrated assessment procedure for long term care services, whereby one assessment is undertaken to determine whether a client requires services from a community-based home care program or requires placement in a nursing home, auxiliary hospital or senior citizen's lodge. It provides for a consistent level of placement decisions on initial entry to long term care, based on assessed need and appropriateness of care. In contrast, under the current system, a client goes through several assessment procedures if he/she is not eligible for the first service contacted.

The need for single entry assessment in Alberta is well documented. The Assessment and Placement Study for Long Term Care of September, 1982 indicated that, in Alberta, the current "lack of coordination of the assessment processes of institutional, community and residential programs is a serious problem." The Hyde Report (March 1982) identified the need for a coordinated assessment and placement service for long term care in Alberta (Coordinated Home Care Program, lodges, nursing homes, auxiliary hospitals). Recommendations for a single point of entry have also been made by the Provincial Senior Citizens Advisory Council and the Alberta Symposium on Aging. Other provinces (e.g., Manitoba, British Columbia) have found the single entry assessment to be cost efficient and to improve the quality of care to the elderly, the primary clients of long term care.

*See Glossary

2. Rationale for a Single Point of Entry

The proposed Single Entry Assessment model responds i) to recommendations for the need for greater coordination in order to provide comprehensive and integrated programs and services to the recipients of long term care and ii) to the problem with the multiplicity of organizations involved in assessment and placement for long term care services.

a) Currently, each long term care service has its own assessment criteria, assessment process and staff to determine eligibility. As there is often little sharing of information among the various services, there is considerable duplication of effort with resulting confusion for the clients, usually elderly persons and their families, and increased cost to the Government. For example, within one geographic region there may be several groups of paid staff assessing for service eligibility. The client may have to go through several different assessment procedures if he is not eligible for the first service contacted.

b) Sometimes the service to which the person first goes (because he knows of it or it is recommended by his physician) is the service he receives, whether or not it is the most appropriate service. The current assessment and placement processes are not adequate to ensure that all placement options are considered when placing a client into the long term care system or transferring a client from one setting to another. The lack of consideration given to non-institutional programs by many important referral sources is particularly significant in this regard. A single entry assessment model provides for an initial comprehensive assessment of the client and his situation with the total range of long term care services within a particular region considered in arriving at the plan of care that best meets his particular situation.

c) Currently, different assessment criteria and processes are used by the various long term care services and in various parts of the

province with the result that there is inconsistency in the way services are arranged for and used by clients in need. Also, the various long term care providers are assessing not so much for client need as for client eligibility--does the client "fit" into the service. On this basis the impartiality of the assessment may also be questioned, as the assessment tools used are developed by the providers of each of the services and used from a service perspective vs. a client need perspective.

d) Currently, the role of "case management"* in long term care services has not received enough emphasis. Therefore, if a client is seen not to be eligible for a particular service he is not necessarily assisted to find the appropriate one(s), (a difficult process for a client who is frail or handicapped and limited in functional capacity). Case management is an attempt to introduce comprehensive case planning based on the client's needs into the long term care system.

e) Because there is a lack of comprehensive care planning involving both the client and his family, some persons receive more services than they need while others go without needed care. Inappropriate use of resources is a very costly feature of the current system that a single entry assessment approach seeks to address.

f) The present delivery of long term care services frequently results in fragmented assessments. That is, the assessment process used generally depends on the skills of one kind of professional only (usually doctor or nurse), which makes it difficult to assess effectively the multiple health and social problems faced by persons in need of long term care. Also, unfortunately all too often the client and his family are not involved in developing the plan for care but rather are told what it should be. The solution to this problem is a single comprehensive assessment and placement process

*See Glossary

that would ensure client access to a wider range of options and reduce inconsistent placements within a region and across the province. Additionally, client/family involvement in the planning of care is a key feature of the single entry model. This enhances the client's right to choose care options.

In summary, one assessment and placement process used by all long term care services within a defined region (a single point of entry) would reduce the costly duplication of assessment services and the problems described. It would provide a focal point, which would enable the long term care services to work together, to combine their efforts and different professional skills and expertise in an assessment and placement process in order to serve their clients more effectively. It will also ensure that appropriate services are delivered to the client.

3. Principles Underlying an Assessment/Placement Model

a) A single point of entry to the long term care system is essential to ensure appropriate care for the clients, primarily older frail and/or functionally disabled persons and younger handicapped persons.

b) Non-institutional long term care services (e.g., day care, day hospital, home care) will be considered an integral part of the long term care system, and the emphasis will be on maintaining and strengthening family and community involvement.

c) The long term care system will be based on a philosophy that care will be provided at the lowest level consistent with the client's needs and, where possible, non-institutional services will be considered the first point of entry to the long term care system.

d) Financial incentives will encourage the client to use the most appropriate, and ideally the least costly, service or services.

e) The assessment/placement process will relate to the needs of the client (not the needs of the services). It will be an attempt to determine the level at which the person is functioning in a variety of areas--physical health, self-maintenance, intellectual, social and emotional areas. It will consider his support systems to determine with him what assistance he needs in order to maintain and/or improve his functioning as best he can. The assessment process will be backed up by expert consultation services whenever possible, and, if necessary, in-patient assessment services.

f) In the assessment process the client's views will be considered; he will retain as much control as possible over the assessment/placement decisions and as much as possible his "independence" will be retained and his informal supports (family, friends, neighbors) will be part of the assessment/placement process. His relationship with his family physician will be paramount and respected. The assessment process will have a problem solving, client-centered approach.

g) Assessment and placement are two different functions. The assessment process will determine the care needed and will be appropriate for both community and institutional services. The placement process refers to the identification of services and accommodation available in the community and the facilitation of a client's access to the most appropriate services and/or accommodation.

h) If placement in a facility is needed, the client will have the right and the responsibility to identify the facility of his/her choice. A facility may only reject applicants on the grounds that it cannot provide the appropriate level of care (the intent of this principle is, as much as possible, to match care needs to resources).

i) There will be an independent appeal process for clients, service providers and physicians concerning assessment and placement decisions.

j) The client will have the security of knowing he will receive timely and appropriate help, that the assessment/placement process and the appeal process will proceed efficiently and effectively, within specified timeframes.

k) The roles and the mandates of the various long term care services will be clearly defined, understood and agreed upon.

l) All long term care services* will participate in the Assessment/ Placement process and will assume responsibility for ensuring appropriate placement and for finding solutions for difficult situations.

m) The assessment/placement process will provide a "case management" function, that is, it will coordinate the service provided for the client and ensure that the client receives appropriate care as needed and on an ongoing basis.

n) The assessment/placement process will ensure that individuals in an emergent situation will be handled through a process established for rush situations.

4. Overview of the Proposed Model for Single Entry Assessment in Alberta

The proposed assessment/placement model for long term care services in Alberta was prepared by representatives of the Departments of Social Services and Community Health, Hospitals and Medical Care, Housing and the Alberta Mortgage and Housing Corporation. The model gives the mandate for the initial assessment/screening process of clients to the home care staff in the local health authorities. The mandate for the institutional placement process of clients is given to the Department of Hospitals and Medical Care. Since in Alberta long term care is provided via three government departments, the model proposed is one that respects

*See Page 24.

the existing legislative mandates of each Department. The potential for a single point of entry linking the long term care components together in a coordinated approach, rather than by integration, is possible without drastically altering current department mandates and responsibilities. Provincial guidelines established to operationalize this model will be approved by the Interdepartmental Committee on Long Term Care (Departments of Social Services and Community Health, Hospitals and Medical Care, Housing and the Alberta Mortgage and Housing Corporation).

Components of the proposed model are briefly outlined below:

a) Referral to Home Care: When the client (usually a frail and functionally dependent older person or a younger disabled person) or his family, friends and/or physician realizes that he is in need of some services--that he cannot manage on his own--contact with the Home Care Case Coordinator in the Health Unit sub-office nearest to his place of residence is made. The client may be at home in an acute care hospital or in a rehabilitation hospital.

b) Home Care Assessment: The Home Care Case Coordinator visits and assesses the client's need for services with him, his family and/or friends, if available. His family physician is also contacted for his assessment of the client and situation. (The assessment tool used will be one that will be developed to look at the total person, his medical condition and physical functioning, his social and emotional needs, his living arrangements and the support he may or may not be receiving from family and friends.)

c) Identification of Services Required: Based on the client assessment, the care required is identified. It may be determined that no service is needed, or perhaps only a referral to a community health nurse for surveillance visits or to a senior centre for friendly visiting is required. If the client needs home-delivered services, the Home Care Case Coordinator will develop a plan of care with the client and his family/friends and arrange for the required services.

The client's situation will be reassessed periodically to determine that care remains appropriate to changing needs.

d) Facility Placement: If the client needs placement in a long term care facility, the Home Care Case Coordinator will refer the client along with the assessment material to the Institutional Case Coordinator. The assessment data will be used to determine if the recommendation for placement in a facility is appropriate and to determine which facility is best for the client. (Additional assessment may be required.) The Institutional Case Coordinator will work with the client and professionals in the region (if desired, a Placement Panel) to ensure an appropriate placement decision is made. In all circumstances, the choice of the client for a particular facility will be taken into consideration. The case coordinator will be responsible to place the client given her/his corresponding responsibility to manage the existing waiting lists.

e) Regional Assessment/Placement Committee: This Committee will have the overall responsibility for placement for long term care in the region. Day to day placement activities will be delegated to its institutional case coordinator. Multi-disciplinary professional input will be ensured through established panels, or resource professionals in the region.

f) Discharge Planning from Long Term Care Facilities: Should the client at some point (or his family, physician or the facility staff) feel that he could be discharged from the institution, the Institutional Case Coordinator will work with the Home Care Case Coordinator to arrange this, if assessment determines that this is appropriate.

g) The Client's Right of Appeal: The client, of course, has the right to refuse the plan of care. He has the right to disagree with recommendations that are being made about his life. He can refuse to accept the care. He has the right to appeal to the Regional

Assessment/Placement Committee and to have his appeal heard promptly and a decision made.

h) Time Lines: Throughout the whole process there will be assurance, because of provincial guidelines established for time lines, that the assessment process will be done within a reasonable time after the referral is obtained and services will be instituted, or, if placement in a facility is needed, that the placement will be made within the limits imposed by the existing waiting lists and the priority of clients on the waiting lists. If it is necessary for the client to wait for a period of time for placement, he will have priority for receiving any needed services on a home delivered basis within the limits of the resources available. Also, local policies and procedures will be established within each Region regarding emergency admissions into the long term care system. Where the routine established for the single entry assessment is inappropriate for the client due to an emergent situation, the established alternative process for assessing and placing the client will be followed.

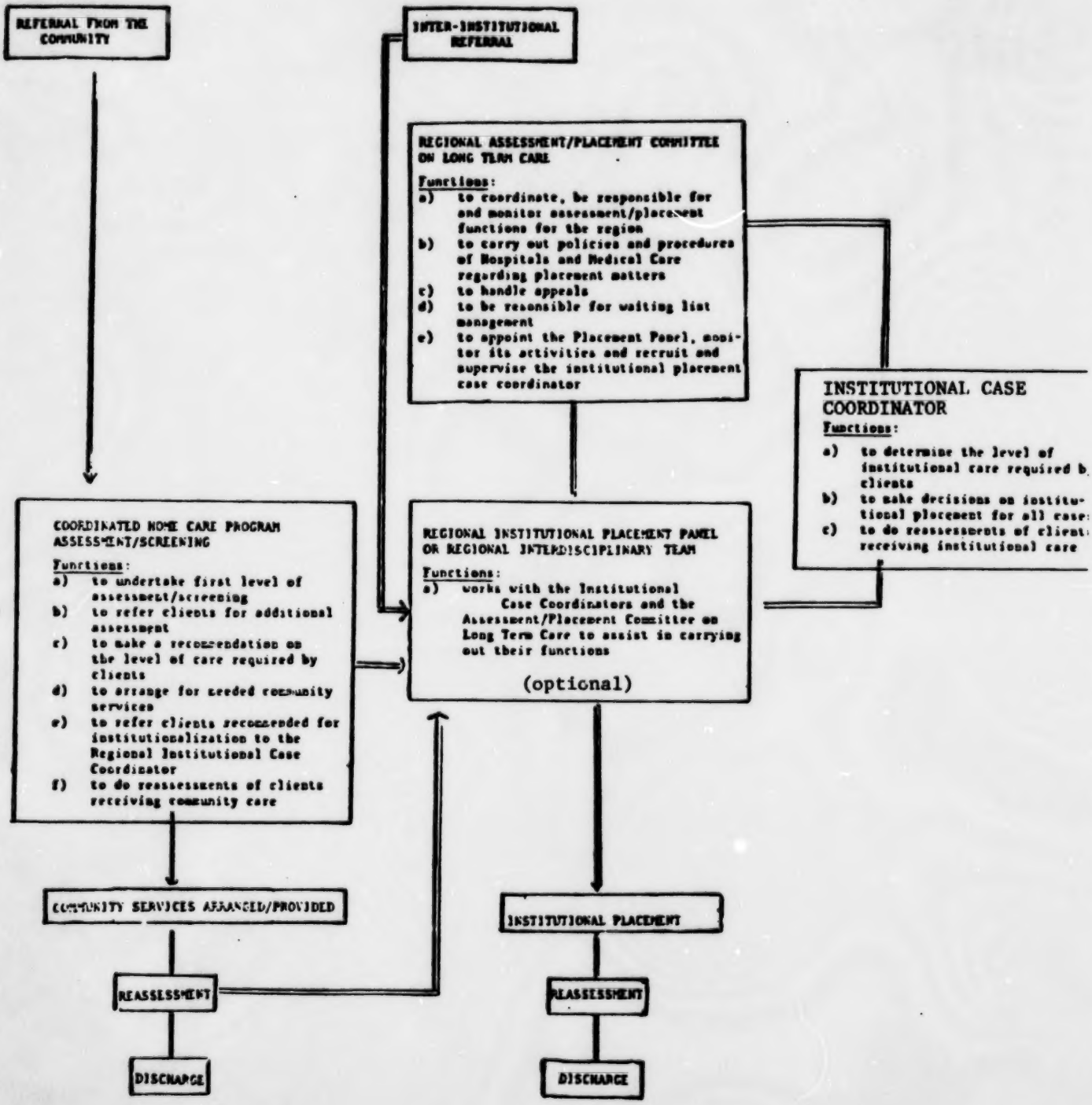
5. Benefits of Single-Entry Assessment to the Client

a) The client, his family and/or his physician will have one place to call to initiate service (so it will be less confusing, tiring and time-consuming).

b) The client will not be exposed to the duplication of effort that currently occurs because each long term care service has its own assessment criteria, assessment process and staff to determine eligibility.

c) The client will be the recipient of an assessment and placement process that may draw on all the long term care resources and respective professions in his geographic area. He will benefit from a greater range of skills in assessment and placement and will have

II. THE PROCESS


REFERRAL FROM THE COMMUNITY
INTER-INSTITUTIONAL REFERRAL
REGIONAL ASSESSMENT/PLACEMENT COMMITTEE ON LONG TERM CARE
Functions:
a) to coordinate, be responsible for and monitor assessment/placement functions for the region
b) to carry out policies and procedures of Hospitals and Medical Care regarding placement matters
c) to handle appeals
d) to be responsible for waiting list management
e) to appoint the Placement Panel, monitor its activities and recruit and supervise the institutional placement case coordinator
INSTITUTIONAL CASE COORDINATOR
Functions:
a) to determine the level of institutional care required b
clients
b) to make decisions on institutional placement for all case
c) to do reassessments of client
receiving institutional care
COORDINATED HOME CARE PROGRAM ASSESSMENT/SCREENING
Functions:
a) to undertake first level of assessment/screening
b) to refer clients for additional assessment
c) to make a recommendation on the level of care required by clients
d) to arrange for needed community services
e) to refer clients recommended for institutionalization to the Regional Institutional Case Coordinator
f) to do reassessments of clients receiving community care
REGIONAL INSTITUTIONAL PLACEMENT PANEL OR REGIONAL INTERDISCIPLINARY TEAM
Functions:
a) works with the Institutional Case Coordinators and the Assessment/Placement Committee on Long Term Care to assist in carrying out their functions
(optional)
COMMUNITY SERVICES ARRANGED/PROVIDED
INSTITUTIONAL PLACEMENT
REASSESSMENT
REASSESSMENT
DISCHARGE
DISCHARGE

greater choices in the plan for care (in placement) because of the range of resources that will be considered for his care.

d) As the emphasis in the assessment/placement process will be on the use of non-institutional services if appropriate and possible, this model will carry out the expressed preference of most older people and handicapped people. Almost all persons want to stay in their own houses or apartments, in as "independent" a situation as possible with the security of knowing that help is available quickly if needed (Resources Management Consultants (Alberta) Ltd., "A Review of the Coordinated Home Care Program," a Report prepared for Alberta Social Services and Community Health, March 1983).

e) Additionally, the "case coordination" function will facilitate the client receiving the required services. For example, if a person has to wait for placement in a facility, alternative services will be arranged for him during the waiting period. He will not become subject to "buck-passing" among agencies, a practice that happens when no one assessment process is formally required to consider all placement options.

6. Detailed Description of the Proposed Model for Single Entry Assessment

a) Referral for Long Term Care Services

- All persons believed to be in need of long term care services and not living in a long term care facility will be referred to the Home Care Case Coordinators (Coordinated Home Care Program) for initial assessment.

- Anyone can make the referral (client, physician, family, for example).

- Upon receiving a referral, the Home Care Case Coordinator will contact the client, whether he is at home or in the hospital,

to discuss the referral, the client's situation and to arrange for an in-home assessment.

- It is not the intent of this model to duplicate existing hospital discharge planning efforts. Where acute care discharge planning is done, referrals to the Coordinated Home Care Program for client assessment will augment in-hospital assessments. The acute care hospital referrals to the Coordinated Home Care Program can be built into a province-wide system that will facilitate the most appropriate use of acute care beds.

- The case coordinator will also contact the client's physician to discuss the referral, to obtain his professional opinion about the client's situation and need for care services. A physician's authorization is required for the client to receive services.

- The Home Care Case Coordinators will be fully-qualified professionals (i.e., a nurse, a physiotherapist, an occupational therapist or a social worker).

b) <u>The Client Assessment by the Home Care Case Coordinators</u>

- The assessment tool used for documenting the client data base will be one approved by the Interdepartmental Committee on Long Term Care (one to be developed with the involvement of various professional representatives of all the long term care services). It will be suitable for use by both home care and institutional professional assessors.

- The initial client assessment will include obtaining data about the client, his medical condition, his physical functioning, and his quality of self-maintenance. It will also include information about his environment, his ability to function safely within that environment and his family relationships and the support offered to him.

- Provincial guidelines will be developed in conjunction with local Home Care Programs for acceptable time frames between receipt of a referral and an in-home assessment. (Local policies will be established.)

- Based on the initial client assessment information, persons may be referred for additional medical, psychological, social, physiotherapy, or occupational therapy assessment. Professionals available through the Home Care Program, the Health Unit and other local services may be called on for consultation and assistance in various aspects and/or in obtaining additional professional opinions.

- Records and reports from the client's physician, service agencies and/or facilities involved may be used (with permission of the client) to provide the necessary client data.

- The case coordinator will assist the client and family/friends in identifying risk factors and will discuss with them any changes they can make to improve the client's well-being. The client support system must be addressed in an assessment process. While it is recognized that the ability of families to help varies widely, they are part of the client's life and positive relationships should be supported and strengthened. Part of the development of a plan for care is to negotiate with the client and the family caregivers to determine how services can most effectively supplement their helping and relieve their stress.

- Regular client reassessments for care requirements will be carried out according to established procedure and policy by the Home Care Case Coordinator while the client is receiving Home Care Services. This will ensure that the services provided on an ongoing basis are appropriate and needed. When service is no longer needed or when increased and/or different services are required (such as institutional placement), the

Case Coordinator together with the client will discharge the client to other community services, alter the client care plan, or refer the client to the Institutional Case Coordinator for institutional placement of the client.

- In those situations where the Home Care Case Coordinator and the client cannot agree on the plan of care, the client will, of course, be able to refuse care or to appeal his care plan (see the section describing the appeal process). As much as possible, the client's concerns will be listened to and the client's right to choice will be considered.

c) Referrals to Long Term Care Facilities

- If a move to a facility is recommended for a client, the Home Care Case Coordinator will arrange for the client assessment data to be referred and presented to the Institutional Case Coordinator who will determine the care required and the appropriate facility placement.

- The criteria for determining at what point (and in what kind of circumstances) referrals for institutional placements should be made, along with the procedures for doing so, will be approved by the Interdepartmental Committee on Long Term Care after being circulated to the field for comments.

d) Regional Assessment/Placement Committee on Long Term Care

i) Terms of Reference/Membership

The Regional Assessment/Placement Committee for Long Term Care will have overall responsibility for assessment and placement for Long Term Care in the region. The Committee will be composed of representatives of the various institutional and non-institutional service components, and consumers (e.g., elderly, disabled). (Each service

component will select its own representative, and one consumer group will be represented.) This Committee will delegate the day-to-day placement activities to its Institutional Case Coordinators.

The Chairman of the Committee will be appointed by the Committee, and paid on a sessional basis by the Department of Hospitals and Medical Care (the job description and qualifications to be developed).

The Committee will meet as necessary to carry out its functions.

The Committee will be composed of one selected representative from each of the following:

- Nursing Home and Auxiliary Hospital District Boards
- Private nursing homes
- District and voluntary nursing homes
- Auxiliary hospitals
- Local Health Authorities
- Lodge Foundations
- Consumers and interest groups
- Acute care hospitals

Representatives may be board members, administrators, professionals, lay people.

ii) Functions

The functions of the Committee will be

- to co-ordinate the assessment and placement functions of the region.

- to be responsible for placements in long term care facilities in the region.

- to receive reports from the Coordinated Home Care Program assessment service for long term care clients and to review high cost clients being maintained in the community.

- to carry out general policy/procedures of the Department of Hospitals and Medical Care regarding placement matters.

- to handle appeals for long term care assessments and institutional placement decisions and thus be accountable to the Interdepartmental Committee on Long Term Care for regional services.

- to manage the placement services within the region; the Committee will recruit and be responsible for the Institutional Case Co-ordinator(s).

- to assess on a continuing basis the functioning of the assessment and placement service and the long term care resources available within the region, reporting on a regular basis to the Department of Hospitals and Medical Care; it should be aware of services other than the long term care services and encourage cooperative efforts locally to meet gaps in resources.

iii) Reporting and Funding

The Committee will be responsible to the Department of Hospitals and Medical Care. The necessary funding for the model will be provided by Hospitals and Medical Care to the Committee. This funding will include administrative

expenses, salary for the Institutional Case Coordinators, travel, consultation services, and other necessary expenses.

The terms of reference for the Committee and guidelines for its operation will be developed by the Department of Hospitals and Medical Care and approved by the Interdepartmental Committee on Long Term Care.

e) Legislative Mandate

It is proposed that the legislative mandate of this Committee be created by enabling legislation which will give authority to the Committee for assessment/placement matters for long term care services. Clauses in the existing Nursing Home Act relating to nursing home and auxiliary hospital assessment and placement committees will be deleted. The enabling legislation can be administered by the Minister, Hospitals and Medical Care, or any other Minister designated by Cabinet.

f) Description of the Placement Process for Long Term Care Facilities

i) Assessment Process for Placement Within Long Term Care Facilities

Provincial guidelines will be developed in conjunction with local services to establish acceptable time frames within which a placement decision must be made. Admission to long term care facilities will be made on the basis of assigned priority and waiting lists. Guidelines will be developed to provide direction for the institutional case coordinator functions.

Local policies will be developed in order to facilitate the process of handling emergency long term admissions to long term care facilities. (It is often imperative to

respond quickly when dealing with clients having health problems resulting in a need for care.)

If all facility beds are full and there is a waiting period before admission, the Institutional Case Coordinator and the Home Care Case Coordinator will arrange for interim services to be provided (with the agreement of the client and his family) within existing, available resources.

The Institutional Case Coordinator will be available for consultation concerning care plans for persons in facilities and for client reassessments and discharge planning. If discharge seems appropriate, he/she will work closely with the Home Care Case Coordinator and the institutional staff to facilitate the clients' discharge.

ii) Role of the Institutional Case Coordinator(s)

The Institutional Case Coordinator(s) will be recruited by and responsible to the Regional Assessment/Placement Committee for Long Term Care in consultation with the Department of Hospitals and Medical Care.

The Institutional Case Coordinator(s) will work with the various providers of facility-based long term care services, with Home Care Case Coordinators and with other professionals involved in long term care. The Institutional Case Coordinator(s) will be the staff responsible to work with the Regional Institutional Placement Panels, where they exist, and the Regional Assessment/Placement Committee.

He/she will review the assessment and recommendation for placement made by the Home Care Case Coordinator, determine the appropriate type of facility for client

placement, arrange for the client placement and provide consultation, as requested, to institutional staff on the development and reassessment of care plans for their residents.

He/she will work for the Regional Assessment/Placement Committee on Long Term Care to

- manage the waiting list for the region.
- monitor and supply information regarding the waiting list to the Department of Hospitals and Medical Care.
- be responsible for various administrative functions relating to the placement process.
- provide the liaison with the Coordinated Home Care Program at a local level.

As the staff person for the Regional Assessment/Placement Committee and any Area Placement Panels, the Institutional Case Coordinator will provide coordination and continuity for the placement process in the region. He/she will ensure that there is some consistency in the process used and decisions made, and that clients needing facility placements in the region exercise their right of choice and that client priorities are set appropriately. This individual (the volume of referrals for a given region may be sufficient to warrant more than one person in this position) will receive appeals and ensure that they are handled promptly. He/she will work closely with the Home Care Case Coordinator and the various service providers in the region to ensure that the most appropriate resources are available for the clients. He/she, along with the Chairman of the Regional Assessment/Placement Committee, will be responsible for gathering the information needed to evaluate the model, to report the operations to the Department of Hospitals and Medical Care, and to recommend ongoing changes for regional long term services.

- The job description for the Institutional Case Coordinator will be developed. The number of institutional case coordinators required for the regions will depend on the volume of cases in each region.

iii) Role of Regional Institutional Placement Panels/Use of Multi-disciplinary Professionals

Regional Institutional Placement Panels

- It will be the decision of the Regional Assessment/Placement Committee in discussion with the Institutional Case Coordinator(s), to determine if a Panel structure will be established in the Region. (One or more panels may be established within a region.)

- Panels would review all recommendations for institutional placement to ensure their appropriateness, provide expert advice to the Institutional Case Coordinator(s), and to the Home Care Case Coordinator(s), and be of particular support in those client situations where there would seem to be no particularly appropriate resource available.

- It is recommended that a Panel be composed of a physician, a nurse, a social worker and a rehabilitation therapist. The physician could be paid on a sessional basis by the Regional Assessment/Placement Committee. Salaried professionals on the panel would be expected to provide this service as part of their regular work. They would be selected by the Regional Assessment/Placement Committee in discussion with local service providers.

- There could be several Regional Institutional Placement Panels within each region, in order to

facilitate reviewing cases efficiently and reducing travel time and costs.

Non-Panel Structure

- Where a Panel forum is seen to be unnecessary by the Regional Assessment/Placement Committee, the Institutional Case Coordinator will handle the placement process, using professionals* of various backgrounds on an individual basis as a resource to ensure appropriate placement decisions within the region.

iv) Inter-Institutional Transfers

Persons who will be discharged from an acute care facility, who normally reside in the community and are in need of long term care services, will be referred to the Home Care Case Coordinator for initial assessment.**

All persons who reside in a long term care facility and who require transfer to another facility (e.g., from nursing home to nursing home, from nursing home to auxiliary hospital, and from acute care back to nursing home/ auxiliary hospital) will be referred to the Institutional Case Coordinator responsible in the area for determination of care needs and the placement decision.

Also, nursing home or auxiliary hospital residents who have been receiving treatment in an acute care facility will, upon discharge from the acute care facility, be referred back to the facility in which they were living or

*Where professionals do not meet as a panel, the assessment should still be client-centered and based on expertise from the various professions.

**See page 10

to the appropriate Institutional Case Coordinator if alternative placement is necessary.

g. The Appeal Process for Long Term Care Clients

The Regional Assessment/Placement Committee for Long Term Care will be the Appeal Body for

- clients who are not satisfied with their initial assessment and/or home care services.

- decisions regarding a recommendation for placement.

- decisions regarding a specific institutional placement.

The Home Care and/or the Institutional Case Coordinator will receive appeals and ensure that they are referred promptly to the Committee. There will be provincial guidelines established specifying the time frame in which appeals must be handled. The Regional Assessment/ Placement Committee will have the authority to request additional assessment of the individual client and his situation.

Client, family, physician or service provider will be able to appeal a decision regarding a client plan for care and client assessment.

7. Ownership of the Initial Client Assessment for Long Term Care

It is the intention of this proposed model to assign the responsibility for initial assessment of long term care clients to the Coordinated Home Care Program. The expanded mandate of the Coordinated Home Care Program will ensure that the program does not merely receive referrals for appropriate home care clients, but that it will have the opportunity to screen all long term care clients and to assess their potential for remaining out of an institutional care setting. It is acknowledged that placing responsibility for the single entry assessment with an existing provider of services introduces a perceived or real conflict of interest

in the selection of placement for clients. However, the three government departments and Corporation agree that a bias directed towards non-institutional services for clients is desirable, and this has also been endorsed in principle by the Nursing Home Liaison Committee.

The proposed model attempts to reduce the conflict of interest possible for the Coordinated Home Care Program in its expanded role by:

a) Establishing provincial guidelines (approved by the Interdepartmental Committee for Long Term Care) that clarify the eligibility criteria for Home Care clients.

b) Requiring the Coordinated Home Care Program to report quarterly to the Regional Assessment/Placement Committee, on its assessment role for long term care including the service needs identified for the clients assessed.

c) Establishing the appeal mechanism for all long term care client assessment/placement decisions (including Home Care Assessment Appeals) with the Regional Assessment/Placement Committee on Long Term Care.

d) Requiring that all Home Care clients, receiving home care services equivalent in cost to institutional placement, be reviewed for decision by the Regional Assessment/Placement Committee on Long Term Care.

8. <u>The Rights of the Client</u>

a) As emphasized in the section on "Principles", client choice and client involvement in the decisions made will be paramount. He, his family if available, and his family physician will be involved in both the assessment and the development of the plan of care to meet his needs.

b) If the plan of care recommends a move to a facility, the client will have a choice of facility commensurate with his care requirements.

c) A client, his family and his physician will all have the right to appeal any assessment/placement decision, and the appeal will be handled within a specified period of time.

d) Throughout the process the right of the client to choice, to have control over his own life and to "independence", will be respected to the greatest extent possible.

9. The Role of the Physician

The physician will continue to have a significant role in providing long term care for clients. Physicians are a major source of referral for clients into the Long Term Care system. The Coordinated Home Care Program is dependent on the physician to provide the medical histories and physical assessment data on behalf of clients admitted to the program. The client's physician must authorize that the home delivered services are appropriate for the client. Signed medical orders are required for the professional home care staff to carry out treatment regimes for clients. The Institutional Case Coordinator will need to consult the client's physician to obtain the medical reassessment data required in order to recommend appropriate placement for the clients. A Placement Panel, or multi-disciplinary professional team, will need to have a physician as part of its membership, in order to review placement recommendations for clients. Physicians, as experienced professionals in gerontology and rehabilitation, will serve as resources in each community to case coordinators, clients, and families to ensure that appropriate care planning is provided throughout the long term care service delivery system. The Regional Assessment/Placement Committee membership may also provide the opportunity for physician participation in the overall administrative functioning of the proposed Assessment/Placement Model.

10. Role of Other Agencies in the Assessment/Placement Model

a) Lodges

i) While municipal lodges are in many ways considered a long term care service, they will continue to handle their own admissions and be viewed as "housing". They will continue to admit elderly persons requiring only food and shelter as traditionally offered by lodges and thus will be considered as a community resource by both the Home Care and Institutional Case Coordinator for those persons requiring food and shelter services. Health care services that can be delivered through the Coordinated Home Care Program will be provided to lodge residents as appropriate. If a resident appears to need more care than the Coordinated Home Care Program can provide, the Home Care Case Coordinator will refer the resident and needed assessment data to the Institutional Case Coordinator for consideration of institutional placement.

ii) Lodges will be represented on the Regional Assessment/ Placement Committee on Long Term Care and as such will take part in making decisions about the overall assessment/placement process and the functioning of the model within the region.

iii) There are a few lodges operated by non-profit organizations and receiving little in the way of public funding (some deficit funding from the Unique Homes Program of the Department of Housing). These lodges will continue to operate independently, but be considered a resource for long term care.

iv) Lodges will continue to control their own admissions. However, in those situations where the resident requires

some health services the single entry assessment provided by the Coordinated Home Care Program will be used.

b) Day Hospitals/In-Patient Assessment, Day Care and Other Services

i) Day care, day hospitals, in-patient assessments, mental health clinics and hospitals and the services funded by Family and Community Support Services will all be viewed as back up resources for the long term care services, both home delivered and institutionally provided. Referrals to these services, as is now, will come from a variety of sources including Home Care, facilities, health professionals, and clients themselves.

ii) The intent of this proposed model is not to encompass all long term care services initially. In this sense, then, it is possible to argue that the proposed model does not provide for a single entry to the long term care system. However, this model does recognize that a single entry system is developmental. The government departments are proposing a phased-in approach for establishing a comprehensive single entry assessment model. The pilot testing experience will determine the appropriate liaison, interface and participation of service agencies.

iii) However, as much as possible, information on the utilization of these programs will be communicated to the Regional Assessment/ Placement Committee in each region, through the Home Care Case Coordinator and the Institutional Case Coordinator.

iv) The Coordinating Committee and the Institutional Case Coordinator will not be responsible for admissions to day-delivered services except on a referral basis. In the same manner the Home Care Case Coordinator will not be responsible for screening admissions to these programs but

will refer persons to them (will use these services in the care planning). Day-delivered services and the Alberta Hospitals (Edmonton and Ponoka) will accept referrals in accordance with their own policies.

v) The long term care services which will be part of the two proposed pilot tests are the Coordinated Home Care Program, nursing homes, and auxiliary hospitals. Acute care hospitals will be involved in that clients requiring long term care services upon hospital discharge will be referred and assessed by the Coordinated Home Care Program. Access to Alberta Hospital Edmonton, Alberta Hospital Ponoka, Rosehaven and Claresholm Care Centres and services to the dependent handicapped are not specifically addressed in this model. Also, other services such as Alberta Mental Health Services, and services funded by the Family and Community Support Services Program, etc. will be involved in this model when the case coordinators (both Home Care based and institutionally based) involve the appropriate community services on behalf of the client. It is anticipated that the pilot testing of this proposed model will determine the appropriate liaison and interface of many community resources as the model is operationalized in two regions of the province.

11. Regional Boundaries: Urban-Rural Differences

a) The Principles on which the Boundaries will be Established are as Follows:

i) The basis for the regions (the building blocks) will be nursing home and auxiliary hospital districts--a grouping of these districts.

ii) Wherever possible, consideration will be given to Health Unit boundaries; an attempt will be made to maintain the regions within Health Unit boundaries.

iii) Regions must be large enough to allow for adequate regional resources (number of facilities, a variety of professionals, for example), thereby reducing the possibility of only a narrow perspective on care alternatives. At the same time they must be small enough to ensure that the members of the Regional Assessment/Placement Committee are quite familiar with the total region, that travel time is not too great (any Institutional Placement Panels in each region will, of course, cover much smaller geographic areas), and that clients retain a sense of community--a local solution wherever possible.

iv) The boundaries for the regions will permit reasonable representation from the various long term care services.

v) Local needs and local autonomy in this model are respected in the proposed negotiation process to establish the regions in response to local needs.

vi) The process for creating future regions (should this model be adopted following the pilot testing in two regions) will involve empirical studies which look at catchment areas, referral patterns, beds and occupancy rates. These studies and existing services boundaries will be examined, and finally through a process of consultation and discussions with local service providers the regional boundaries will be determined.

b) Urban-Rural Differences

i) It is recognized that this proposed model may need to be modified in response to urban and rural differences. As regional boundaries are negotiated, modifications of this model structure will be necessitated. Consideration will be made to simplify the model as appropriate for rural regions.

ii) If it is decided to implement this model on a province-wide basis, changes to this model will be considered to accommodate rural areas where existing long term care services are functioning cooperatively and effectively.

12. Proposed Implementation of the Model (Two Pilot Tests)

An effort will be made to establish the pilot testing of this model in two regions where the local providers of long term care services are interested and supportive of this proposed model. In discussion with the local people, the Departments will determine the boundaries for the pilot regions, and will help those involved to establish the Committee and the Placement Panels (if desired). A single entry assessment tool, to be developed through a cooperative effort of the three Departments and the Corporation and direct service staff, may be available for the Home Care Case Coordinators to pilot test in the trial period.

It is recognized that it will take time to establish the model within the regions. The trial period will be two years and during that time the model may well be adjusted as the advantages and disadvantages of various structures are evaluated. It will be important to build on what is working well in each region and to use existing resources in developing the model in the pilot sites. During this trial period the assessment and placement services in other parts of the province will remain unchanged.

13. Evaluation

An evaluation procedure will be an essential part of instituting the assessment/placement model. The evaluation procedure will be built into the service from the beginning, along with systems for collecting appropriate planning data.

The major purpose of the evaluation is to look at the structure and the process of the model to provide information for the purpose of making adjustments to the model as it is operating.

In addition to looking at the structure and process, the evaluation may look at the impact of this assessment/placement process on the long term care system. It may address the following:

a) The target populations for long term care--who are they? Who are the "at risk" populations?

b) Medical/health status and functional dependency in various target groups, and needed support and rehabilitation services.

c) What are the most effective ways of delivering services to the various target groups?

d) What supports can family and other caregivers provide? Are there ways of more effectively assisting them to help the client?

These are only a few of the possible questions that could be explored during the testing period of the model.

14. Costs of Implementing the Proposed Model

a) Background: The Problems

i) The numbers of persons age 65 and over are increasing. It is expected that this portion of our population may almost

double in number within the next twenty to twenty-five years and that persons age 85 and over (the major clients of long term care services) may increase in their proportion of the senior population. The growing number of elderly persons will impose an increasing strain on existing physical, human and financial resources. In fact, population projections indicate that the health care system cannot continue to institutionalize the elderly at the present rate.

ii) Suggestions submitted to a Task Force on the Allocation of Health Care Resources* repeatedly recommended a new program of care for the elderly which would emphasize independent and productive living at home. The majority of elderly people would prefer to be in the community, living in their own homes, rather than living in institutions. There is strong evidence to suggest that this is not only possible, but economically attractive if the right support systems could be put in place. The problem is that at present, in many places, these support systems are grossly inadequate.

iii) Since many of the persons who enter institutions for long term care services can no longer maintain their home and lack a support system for remaining in the community, de-institutionalization of nursing home and auxiliary hospital clients is very difficult. The difficulties associated with de-institutionalizing the long term care elderly suggest that any strategy to achieve immediate cost savings through de-institutionalization may be problematic.

*Canadian Medical Association, Health, a Need for Redirection. (A Task Force on the Allocation of Health Resources.) Ottawa: Print Action Ltd., 1984.

iv) This finding has to be considered in conjunction with the judgement that there is a high proportion of institutional residents who are inappropriately placed. No surveys have been completed in Alberta to assess inappropriate placement of institutionalized clients for long term care. Studies in other jurisdictions, most of which have lower bed to elderly population ratios than Alberta, found that between 10% and 40% of those institutionalized were inappropriately placed (U.S., Congressional Budget Office, 1977).

v) Services in Alberta have experienced a period of rapid growth in expenditures during the last five years as a result of an increase in population growth and improvement of the economy. The fiscal constraints currently facing the Government of Alberta dictate that such rapid growth in expenditures cannot be entertained in the future. At the same time, the elderly population in Alberta, as mentioned earlier, is projected to increase in the decades to come, which will create an increased demand, almost certainly, for long term care services.

b) Cost Containment Strategies

i) Given the findings on the difficulties of moving people out of institutions once they are there, the most plausible strategy for dealing with inappropriate use of institutions is to adopt screening controls for institutional admissions and focus program efforts on those "at risk" of being institutionalized. (The disadvantage of such a diversion approach is that it will not result in major cost savings over the short term, since it will be some time before it translates into significantly lower levels of institutionalization.)

ii) By investing in community based services and by screening institutional admissions, we can anticipate avoiding large expansions of the institutional system. Since the total size of the elderly is growing, there may not be a decrease in the absolute number of the elderly in institutions.

c) Costs of Pilot Testing the Proposed Model

There will be some cost involved in the establishment of the two pilot regions for testing the assessment/placement model. As much as possible, existing staff in the various services will be used to carry out the functions. Presently, Home Care and district staff are performing assessments, and they will be given the mandate to carry out the initial client screening assessment for long term care services. The volume of additional assessments to be done will determine the additional staff required. Community professionals will also be used for any placement panels established. Community professionals will be representing their services on the Regional Assessment/Placement Committee. Funding will be needed to cover travel costs and administrative expenses connected with these two bodies. There may be costs involved in establishing and maintaining the information systems needed, for waiting list management and the evaluation process. However, as pointed out in the section, "Ration ale for a Single Point of Entry," there is presently duplication of effort in assessment and placement, and this is costly. The two pilots will test a way of using the existing human and financial resources more efficiently and effectively.

d) Summary

While there will be some costs connected with the implementation of this model in two pilot sites, such a step is necessary in these times of economic restraint if we are to redirect our course. No institutional beds will be closed (in fact more may be needed in the future), but by using lower cost service alternatives as appropriate

we can contain these government expenditures. Failure to do so will place an increasing burden of expenditures on future generations of Albertans. Finally, failure to look at new ways of coordinating our long term care services will mean that we, in the future, will fail to use our resources most effectively to meet the health and social service needs of a small, but vulnerable, segment of our population--frail and the functionally dependent older persons and younger severely disabled persons. Alberta needs to provide long-term care services in a way that provides more client choice, is more satisfying to the clients and promotes their maximum functioning and involvement in community and family life (quality of life).

LONG TERM CARE ISSUES RELATED TO SINGLE ENTRY ASSESSMENT

Many of the issues and problems in assessment and placement for long-term care services in Alberta relate more to the structural characteristics of the system than to the process itself. Thus, in order to comprehensively address the issues and problems related to assessment and placement, relevant recommendations for modifications to the structure of the long-term care delivery system in Alberta will need to be addressed. These related issues are not addressed in this proposed model; however, this model would be compatible with structural changes/improvements in the following areas.

a) Shortage of Placement Options

The most prevalent related issue is the shortage of placement options within the long term care system in many communities and the impact of this shortage on the integrity and efficacy of the placement process. In many smaller communities particular types of service and facilities are either unavailable or in short supply. In the larger communities, although most types of programs and facilities exist, many are unable to accept appropriate referrals because of shortage of beds and/or resources within their program.

The prevalent practice of keeping people in inappropriate placements rather than placing them outside the local area when the most appropriate placement option is unavailable may be having a negative impact on both the system and the well-being of the client. This inappropriate placement may strain the resources of the receiving facilities/programs if the client requires more care than can normally be offered. If the client does not require the full care provided, the resources of the facility/program are underutilized and the level of functioning of the client may deteriorate as he/she develops a dependency on the care available.

b) Lack of Integrated Levels of Care for Long Term Care Clients

Client transfer between facilities frequently becomes necessary when care requirements change, because of the limited capabilities of single level care facilities.

c) Client Classification

Client classification systems for long term care relate to the issue of funding long term care institutions by client care requirements.*

d) Lack of Community Resources for Non-Institutional Placements

Respite programs would facilitate non-institutional placements. Families would be more inclined to care for disabled, chronically ill or impaired elderly family members if they were confident that ongoing support and periodic relief was available. Day Care services for adults and day hospital programs as well as transportation services need to be developed if non-institutional alternatives are to be considered for Long Term Care clients.

e) One Common Assessment Tool for Long Term Care

One of the major barriers to effective information transfer for long term care clients will be addressed in the development of one common assessment tool for all long term care service agencies in Alberta. This model implies a common assessment tool for long term care to provide a mechanism for information exchange among all long term care programs.

f) Client Registry Information Systems

The model also does not provide for an automated central registry of long term care applicants and/or services. Although data collection and

*See Glossary

analysis is recognized as important for caseload management, waiting list management, determination of service utilization and ongoing system evaluation and planning, this model is not dependent on introducing a sophisticated long term care information system initially. It does allow for developing such a system and incorporating it into the model at a later date.

g) Education

It will be important that the personnel who are involved in the assessment/placement service, in particular the Home Care Case Coordinators, the Institutional Case Coordinators and members of the Area Placement Panels/multi-disciplinary professional teams have an opportunity for continuing education. This is particularly necessary in work with elderly clients who often have multiple and complex health, social and psychiatric problems. Skill in assessment of complex situations, particularly psychiatric problems, and also in assessing potential for rehabilitation, is crucial. Programs of continuing education are not addressed in this model.

h) Other

Other related issues not addressed in this model include such things as deficiency in programs and programming for special needs groups and lack of discharge planning for long term clients.

GLOSSARY

1. "Long term care may be interpreted as one or more services that are required on a sustained basis to enable individuals, whose functional capabilities are chronically impaired, to be maintained at their optimum levels of health and well-being. Long term care may also include rehabilitation services to restore individuals to their optimum levels of independent functioning. These services may be provided on a non-institutional basis (e.g. home care, day hospital/day care) to persons living in their own homes or in lodges; they may also be provided within an institution (e.g. nursing home, auxiliary hospital). Effective and efficient care delivery depends on coordinating the various services and matching particular services with specific persons' needs, that is the processes of assessment and placement.

2. "Case management" is a process and method of assessing a person's needs, establishing a plan to deal with these needs, implementing the plan directly or by referral and ensuring, finally, that the plan has been fully carried out or revised as necessary on an ongoing basis.

3. Single Entry Assessment is an integrated assessment procedure for long term care services, whereby one assessment is undertaken to determine whether a client requires services from a community-based home care program or requires placement in a nursing home, auxiliary hospital or senior citizen's lodge. It provides for a consistent level of placement decisions on initial entry to long term care, based on assessed need and appropriateness of care.

4. Assessment refers to the collection of information on a client's functional abilities, psychosocial status, medical requirements and his support system and environment to make recommendations regarding ideal and/or suitable accommodation and services to meet a client's need.

5. Placement refers to the identification of services available in the community and accommodation and to making recommendations concerning the

most appropriate services and accommodation and facilitating access to them.

6. Admission refers to the process of accepting (or rejecting) an application and admitting the client to a long term care facility or program.

7. Discharge Planning refers to the process of planning for the discharge of a client to or from a long term care facility or program.

8. Patient Classification refers to categorizing clients into mutually exclusive and exhaustive categories according to their particular combination of distinct dimensions of client care needs.